Carroll County Mental Health Advocates
Client Referral Form

CARROLL COUNTY
MENTAL HEALTH ADVOCATES
THE MISSING LINK TO MENTAL HEALTH

Referring Organization* _____

Referrer Name* _____

Incident Date & Time ____/____/_____
Case # _____

Referrer Contact Info* _____

Client Name* First: _____ Last: _____

Date of Birth* ____/____/_____

Sex* ☐ Female ☐ Male ☐ Undifferentiated ☐ Unknown

Race* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Multiracial ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race
☐ White ☐ Undisclosed ☐ Unknown

Client Phone* _____ **Secondary Phone** _____

Homeless?* ☐ Yes ☐ No
If yes, list areas frequented: _____
Client Address* _____
(Optional if homeless) _____

Reason for Referral* ☐ High risk for crisis recurrence ☐ Follow up from inpatient hospitalization
☐ Needs further crisis intervention ☐ Multiple 911 calls ☐ Requests community resources
☐ Requests mental health resources ☐ Only to notify of incident - no further needed
Discussion: _____
_____
_____

Law Enforcement Intervention ☐ De-escalated, left at scene ☐ Refused all
☐ Transported to hospital via EMS ☐ Transported to hospital via LEO
☐ Arrested on city charges ☐ Arrested on state charges ☐ None needed

Previous MH Diagnoses/Treatments (Include any Behavioral Health): _____
_____
_____

Chief Complaint* ☐ Mental Health Crisis ☐ Substance Misuse Crisis
☐ Harm or risk to self ☐ Harm or risk to others

Comments:_____
_____

Sent completed form to: **crisisreferrals@carrollcountyga.com** or Fax 470-665-4517